

AUSTRALIAN INDIGENOUS LAW REVIEW

2008 • Volume 12, Special Edition 2



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AUSTRALIAN INDIGENOUS LAW REVIEW

2008 • Volume 12, Special Edition 2

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Since 1981 the Indigenous Law Bulletin has led the way with accessible, accurate and timely information about Australia's Indigenous peoples and the law. We write for legal practitioners, advocates, policy makers, researchers and students. We cover legislation and government policy, case law, parliamentary proceedings, international developments, local activism and the work of Indigenous communities and organisations.

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EDITORIAL NOTE

The *Australian Indigenous Law Review* ('AILR') is a DEST-approved publication unique for its currency, wide range of material, expert commentary and international perspectives. It draws together legal materials from all areas affecting Indigenous peoples in Australia and around the world.

The AILR publishes detailed, peer-reviewed commentary from leading Australian and international experts. It also includes recent and relevant case law, publishing the most prominent cases alongside those which would otherwise go unreported. In furthering the transition from its previous incarnation as a reporter-style journal to a review, and in recognition of the increased availability of primary source materials online, the AILR has in 2008 strengthened its focus on commentary, and also removed the Digest section.

Information is presented in an accessible, easy-to-read format. The AILR includes a cumulative index in the last volume of each edition.

Previous volumes of the AILR are available online at AustLII. The AILR is designed to complement the Indigenous Law Centre's long established publication, the *Indigenous Law Bulletin*.

Previous editions of the AILR are available online at <<http://www.austlii.edu.au/au/journals/AILR/>>.

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The editors wish to extend their thanks to the various Australian Aboriginal and Torres Strait Islander legal services, whose contributions to and cooperation in the production of this edition have been invaluable. The editors would also like to thank the Editorial Panel, Prue Vines, Janette Murdoch, Dani Johnson, Talia Epstein, the Indigenous Policy and Service Delivery Branch and the Indigenous Law and Justice Branch of the Commonwealth Attorney-General's Department, John Hewitt, Zrinka Lemezina, Sonia Cooper and Michelle Bradley for their contributions to the creation and production of this edition of the AILR.

Artist's Note

The cover artwork is entitled *Country* and is by Hazel Morton Kngwarrey. Hazel hails from the Ngkwarlerlanem and Arnkawenyerr areas of country, which are parts of the Utopia region in the Northern Territory. Stories told in the work are of Hazel's country, including of *boor-la-da* (rainbow), *tharrkarr* (sweet honey grevillea) and *yerramp* (honey ant). Prior to beginning painting in 1991, Hazel worked in the batik medium, though she has since become established in a variety of media. She is one of many artists in a large family, and her work has been exhibited widely in Australia and internationally.



EDITORS' INTRODUCTION

Welcome to the second AILR Special Edition for Volume 12, which takes as its theme 'Coronial Reform and Preventing Indigenous Death'. We are nearing two decades on after the conclusion of the Royal Commission into Aboriginal Death in Custody ('RCIADIC'), the inquiry established to investigate the high rates at which Aboriginal and Torres Strait Islander people were dying in prisons, police cells and juvenile detention centres around Australia. Among the many issues brought to light by the RCIADIC's extensive five-volume *National Report* were substantial deficiencies in the coronial systems in operation throughout Australia's States and Territories. Many of the RCIADIC recommendations for the improvement of coronial law remain unimplemented.

One of the key messages to emerge from the RCIADIC on the issue of coronial reform was the need to enhance the increasingly recognised preventive function coronial inquests can have – a function chiefly resident in the coronial recommendation-making power. Following the conduct of a thorough investigation into a death, a coroner, having ascertained the circumstances and causes of the death, has the power to make recommendations to government and other agencies in order to prevent the occurrence of further deaths in similar circumstances. Despite this recommendation-making capacity possessed by coroners, in most Australian jurisdictions there is no obligation on government and other agencies to respond to or even consider the potentially life-saving recommendations that come out of coronial inquests.

Making the need for a robust and effective coronial system all the more urgent are the tragically high rates of mortality and lower life expectancies that are a statistical reality for Aboriginal and Torres Strait Islander peoples. Clearly, it is crucial that the preventive potential of coronial inquests is fully realised so as to avert the occurrence of further Indigenous deaths and to, in whatever way possible, help reverse such alarming statistics. Yet it is also plain, as many pieces in this edition show, that effective and culturally sensitive coronial processes are required to show respect for the deceased and their families.

The original impetus for this Special Edition came from a study conducted by Professor Ray Watterson, Penny Brown and John McKenzie, which investigated the implementation of coronial recommendations throughout Australia. While this national study uncovered some successes in coronial process, the key findings of the study reveal the repeated neglect of coronial recommendations in the absence of a consistent legislative framework. The report of that study forms the centrepiece of this Special Edition.

The other pieces published in this edition were primarily sourced from people working in Aboriginal and Torres Strait Islander legal services across Australia. These pieces provide important insights into the different coronial systems operating throughout Australia, and voice the concerns of the Aboriginal and Torres Strait Islander families, and their representatives, who have involvement with the coroner. To preserve the essence of these pieces, they have not, unless otherwise indicated, been peer-reviewed.

Aboriginal and Torres Strait Islander people should be aware that some of the articles reproduced in this edition contain the names of deceased persons.

NB. As this edition was going to print, a number of amendments were made to the Victorian Coroners Bill 2008. The amended Bill was subsequently passed, and received Royal Assent on 11 December 2008. Of the greatest relevance to this Special Edition was the amendment requiring that public statutory authorities in receipt of coronial recommendations must respond to those recommendations within three months, advising of any action taken in relation to the recommendations.

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FOREWORD

The Hon Bob Debus MP
Minister for Home Affairs

It gives me great pleasure to introduce this Special Edition of the *Australian Indigenous Law Review*. The articles in this important collection examine a range of options for coronial reform against the background of recommendations made by the Royal Commission into Aboriginal Deaths in Custody ('RCIADIC'), a survey of current coronial procedure and significant proposals for reforms.

Almost two decades after the RCIADIC delivered its final report, the plight of Indigenous people who come into contact with the criminal justice system remains urgent. Indigenous Australians continue to be grossly over-represented in prison populations, incarcerated at 13 times the rate of non-Indigenous persons. Added to this, the Australian Institute of Criminology's National Deaths in Custody Program reports that the relative proportion of Indigenous to non-Indigenous deaths in police custody and custody-related operations has been increasing since 2002.

The calls for coronial reform within this Special Edition pay attention to, but extend well beyond, investigations into Indigenous deaths in custody. Indeed, the issues considered here go straight to the heart of the challenge confronting all Australians today: the urgent need to redress the particular disadvantage of Indigenous people in the criminal justice system. More explicitly, the authors underline the important role that coronial investigations and subsequent recommendations can play in addressing this disadvantage for Indigenous and non-Indigenous people.

An obvious response to this challenge is for governments and other parties to prevent Indigenous deaths wherever there is the knowledge and capacity to do so. Coronial recommendations following the investigation of a particular death have the capacity to set new standards in areas such

as policing, corrective services and public health. And yet, as the authors in this volume emphasise, coronial processes can only fulfil this preventive role if recommendations are implemented by governments and other responsible parties.

Several articles highlight the lack of means currently available in Australia to monitor the implementation of coronial recommendations. While some jurisdictions have enacted legislative requirements to formally respond to coronial recommendations, the authors suggest there is a lack of scrutiny of whether they have been implemented. Arguably, this makes it difficult to evaluate just how effective coronial inquests are in delivering public health outcomes that reach beyond the particular case in question.

The RCIADIC highlighted the importance of coronial processes as critical, independent points of review. States and Territories each have their own legislation which provides for the conduct of coronial investigations, including any requirements for the government to respond formally to recommendations. For its part, the Australian Government is facilitating greater cooperation between all jurisdictions in areas impacting Indigenous law and justice outcomes such as policing, corrections, juvenile justice and family violence prevention. The development through the Standing Committee of Attorneys-General ('SCAG') of a National Indigenous Law and Justice Framework is one example of how the Government is forging a nationally consistent approach across a broad range of issues. The development of a national approach to coronial recommendations could be a component of that Framework.

I commend the editorial team at the *Australian Indigenous Law Review* and the authors for their thought-provoking work in this complex area of law and policy. While the

views expressed in this journal are not necessarily those of the Australian Government, I welcome ongoing and open dialogue about how governments at all levels might work together so that they can be more responsive and accountable in coronial processes and, most importantly, prevent further unnecessary deaths of Indigenous peoples in this country.

REPORT



CORONIAL RECOMMENDATIONS AND THE PREVENTION OF INDIGENOUS DEATH

Ray Watterson, Penny Brown and John McKenzie*

Coroners ... have a role to play in public health and safety; their recommendations as a result of inquests can pave the way for much-needed social and administrative change.

– The Honourable Marilyn L Warren AC,
Chief Justice of the Supreme Court of Victoria¹

I Introduction

This report details on a national study of the law and practice relating to coronial recommendations undertaken by the authors.² The study collected and analysed data on the implementation of coronial recommendations, and carried out a number of case studies which examined the factors impacting upon whether or not coronial recommendations were implemented. An initial aim of the research was to compare the implementation of coronial recommendations arising from Indigenous deaths with the implementation of those arising from non-Indigenous deaths. However, such a comparative study was abandoned when it became apparent that the recording of Indigenous status in relation to inquests is not wholly reliable.³ It was realised that any meaningful exploration of coronial recommendations in relation to Indigenous deaths needed to be preceded by a national study of coronial recommendation implementation practices more generally. Unfortunately, no such study existed. This research attempts to provide such a study.

Coroners, part of State and Territorial justice systems, are responsible for the investigation of unexpected deaths. Coroners are also empowered to make recommendations aimed at avoiding preventable deaths. All Australian jurisdictions expressly provide for the right of a coroner to make recommendations or comments.⁴ Increasingly, coroners bring a preventive focus to their investigations and, accordingly, have a vital role to play in the avoidance of

Indigenous deaths.⁵ A number of reports have pointed to the significant contribution coronial recommendations can make to the development of public policy and action to prevent avoidable deaths.⁶ However, in most jurisdictions there is no statutory obligation on the agency or organisation to which the coronial recommendations are directed to consider or respond to them. Additionally, there is little publicly available information about whether or not coronial recommendations are in fact implemented and the Australian research in this area, although valuable, is limited in scope.⁷ It is therefore not possible for governments, coroners or the community to assess the impact of coronial recommendations upon the prevention of deaths in Australia, generally or in any particular kind of death.⁸ As Ian Freckelton has observed, it is important for the community to know which proposals are not implemented and the associated reasons. The reasons may be sound, or they may not be, but the families of the deceased and the community generally should be informed of them.⁹

As discussed in greater detail later, the study described in this report considered 185 coronial matters which produced 484 recommendations. The proportion of coronial recommendations implemented in the matters where responses were received by the study varied, from 27 per cent in Victoria, 41 per cent in Tasmania, 48 per cent in New South Wales, 50 per cent in Western Australia, 52 per cent in South Australia, 65 per cent in the Northern Territory and 70 per cent in the Australian Capital Territory. We obtained inadequate information about Queensland coronial recommendations and were therefore unable to include this jurisdiction in the study. However, in 2006, after our study was completed, the Queensland Ombudsman published a report of a study which it had undertaken into practices relating to the implementation of coronial recommendations

in that State. A summary of the Ombudsman's findings and recommendations relevant to our study is included later in this report.

The case studies undertaken and the data collected by our study indicate that a number of factors may affect implementation of coronial recommendations. These factors include:

- the feasibility of a coronial recommendation;
- whether or not implementation of a recommendation accords with government policies and priorities;
- the manner in which a recommendation is formulated or expressed by a coroner;
- the manner in which a recommendation is distributed or communicated by a coroner;
- whether or not a pro-active system for review of recommendations exists within the organisation to whom the recommendation(s) is directed;
- whether or not a mandatory system of reporting organisational responses to recommendations is in place;
- whether or not prior coronial recommendations arising out of similar deaths are drawn to the attention of relevant authorities by coroners or others;
- whether or not an inquest and its recommendations attract media attention; and
- whether or not some form of public advocacy accompanies the recommendation.

Of particular concern were our study's findings of the recurring instances where coronial recommendations had not been communicated or had been miscommunicated, or were lost within bureaucratic processes. In the absence of a legislative system which compels consideration and public report, this seems to be a factor which will hinder the consideration and implementation of recommendations into the future. One of the primary recommendations of the study is that uniform national legislation be enacted compelling public reporting of, consideration of, and response to, coronial recommendations.

So what are the implications of failings in the coronial system for Indigenous communities? Indigenous Australians are one of the most profoundly disadvantaged groups in contemporary Australian society; they continue to fall well below relevant national benchmarks on virtually every measure of wellbeing and socioeconomic status.¹⁰ This profound disadvantage is

reflected in Indigenous mortality, health, and injury statistics: Indigenous Australians can expect to die 17 years earlier than their non-Indigenous fellow Australians;¹¹ Indigenous babies are more than twice as likely to die within their first year;¹² death rates for Indigenous infants are about three times higher than the general Australian population;¹³ compared to the rates for non-Indigenous Australians, hospitalisation rates for Indigenous people are higher for most diagnoses, including 14 times higher for care involving dialysis.¹⁴ In the Northern Territory in 2006, the leading cause of premature death amongst Indigenous men was reported to be motor vehicle accidents, and amongst Indigenous women it was reported to be homicide.¹⁵

Indigenous communities face statistics such as these as a reality of their existence. It is therefore a matter of particular concern for Indigenous communities that coronial recommendations, aimed to prevent further avoidable deaths, are given appropriate consideration and implemented where it is appropriate to do so. A legislative system compelling consideration and response to these recommendations would represent a significant improvement in the situation that this study reveals currently exists.

II Context for the Development of Coronial Law in Australia

A The Royal Commission into Aboriginal Deaths in Custody

[T]horoughly conducted coronial inquiries hold the potential to identify systemic failures in custodial practices and procedures which may, if acted on, prevent future deaths in similar circumstances. In the final analysis adequate post death investigations have the potential to save lives.

– Royal Commission into Aboriginal Deaths in Custody, *National Report*¹⁶

The Royal Commission into Aboriginal Deaths in Custody ('RCIADIC') was established in October 1987, following public agitation led by members of the Indigenous community, amid growing public concern that there were too many Indigenous deaths in custody. In its *National Report*, handed down in 1991, the Royal Commission concluded that the high Aboriginal custodial death rate resulted not from any special propensity of Aboriginal people to die in custody but from their gross overrepresentation in custody.¹⁷ This finding led the Royal Commission to explore the underlying causes of

Aboriginal overrepresentation in custody and to consider means for reducing the disproportionate incarceration of Indigenous people. The Royal Commission addressed the socially, economically and culturally disadvantaged position in which Aboriginal people find themselves and offered practical suggestions to reduce the risk of Indigenous incarceration and deaths in custody.

Revealed by the Royal Commission was the pervasive and troubling failure of the coronial structure in every State and Territory to supply the critical analysis needed to uncover the reasons for Aboriginal deaths in custody.¹⁸ It was concluded that the failure of coronial inquests to uncover the underlying causes of Aboriginal deaths in custody and to recommend remedial action had contributed to the nation's massive failure to prevent many Indigenous deaths.

The Royal Commission's *National Report* provided an impetus for more widespread reform and modernisation of the coronial jurisdiction. It was concluded by the Royal Commission that Australian coronial systems should accord coroners the status and powers to enable comprehensive and coordinated investigations to take place. These investigations should lead to mandatory public hearings productive of findings and recommendations that seek to prevent future deaths in similar circumstances. The Royal Commission recommended an expansion of coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths.¹⁹ The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.

A series of 34 fundamental and interrelated recommendations concerning the framework for the proper conduct of Indigenous death in custody investigations were made by the Royal Commission. Importantly, five of those recommendations referred to a system of communicating recommendations and reporting on their consideration and implementation.

B Reporting Scheme for Coronial Recommendations

It was emphasised by the Royal Commission that the effectiveness of coronial recommendations in reducing Indigenous death rates depends on proper consideration and response to recommendations by the government agencies responsible for their implementation. Recommendations 14–18 made by the Royal Commission provided for a public reporting and review system of coronial recommendations and responses by governments to them.

Recommendation 14:

That copies of the findings and recommendations of the Coroner be provided by the Coroners Office to all parties who appeared at the inquest, to the Attorney-General or Minister for Justice of the State or Territory in which the inquest was conducted, to the Minister of the Crown with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate.

Recommendation 15:

That within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person.

Recommendation 16:

That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 15, provide copies of each such response to all parties who appeared before the Coroner at the inquest, to the Coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations.

Recommendation 17:

That the State Coroner be required to report annually in writing to the Attorney-General or Minister for Justice, (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to findings and recommendations made by Coroners pursuant to the terms of Recommendation 13 above and as to the responses to such findings and recommendations provided pursuant to the terms of Recommendation 16 above.

Recommendation 18:

That the State Coroner, in reporting to the Attorney-General or Minister for Justice, be empowered to make such recommendations as the State Coroner deems fit with respect to the prevention of deaths in custody.²⁰

The scheme envisioned in these recommendations sought to make governments publicly accountable for their consideration of coronial recommendations aimed at reducing the Indigenous custodial death toll. In recommending the scheme, the Royal Commission gave the following rationale:

the ultimate decisions on policy, procedures and practices of custodial authorities must reside with the government, relevant ministers or senior administrators. However, just as the holding of an inquest into a death in custody and the making of recommendations to prevent similar deaths are matters of public interest, equally it is in the public interest that some mechanism be established to ensure that the relevant authorities have received and considered those recommendations. It may well be, in some situations, that there are substantial reasons for not adopting the coroner's recommendations. It is not a question of compelling the government or public authorities to act on recommendations, but rather to ensure that they have received proper consideration.²¹

In this report we argue that a reporting scheme for coronial recommendations of the kind first envisaged by the Royal Commission should be applied to recommendations arising from all deaths investigated by a coroner.

After extensive consultation with the Aboriginal and Torres Strait Islander community and through the processes of a joint ministerial forum, the Commonwealth and all State and Territory governments responded to the Royal Commission's

recommendations in 1992. The Commonwealth Government and all State and Territory governments supported recommendations 14, 15, 17 and 18. Only recommendation 16 failed to attract unanimous support, with South Australia, Tasmania and the Northern Territory not endorsing it.²² Unfortunately, despite overwhelming support for the Royal Commission's scheme for mandatory reporting and review of coronial recommendations relating to deaths in custody, that scheme has not been uniformly implemented by legislation throughout Australia, almost two decades later.

C The Current Picture

There is no uniform national system which reports whether or not coronial recommendations have been implemented by responsible government agencies. Nor is there a uniform national scheme which ensures that coronial recommendations are properly considered by responsible government agencies. Furthermore, there is no system in place which ensures that all coronial recommendations arising from Indigenous deaths in Australia are recorded in a form readily accessible to those who could draw from them in helping to prevent Indigenous death – for example, Indigenous communities, Indigenous health workers, coroners, and government and private agencies with a responsibility for, or interest in, Indigenous wellbeing.

Only three jurisdictions, the Northern Territory, South Australia and the Australian Capital Territory, have legislation requiring any response to coronial recommendations by government agencies. In the Northern Territory this requirement applies to all matters in which recommendations are made that relate to a Northern Territory government agency or the police force.²³ In South Australia it applies only in relation to deaths in custody.²⁴ In the Australian Capital Territory it applies only in relation to deaths in custody and then only with respect to the custodial agency in whose care the person died.²⁵ Each of these three jurisdictions requires some form of public reporting of responses.²⁶

In September 2006, after our study was completed, the Law Reform Committee of the Victorian Parliament, having carried out a review of the *Coroners Act 1985* (Vic), recommended many reforms of the coronial legislation in that State, some of which are also suggested in this report. Acknowledging that coronial investigations 'may be a wasteful exercise if the [resulting] recommendations can be ignored by those to whom they are directed', the Committee recommended the

introduction of a mandatory response regime in Victoria.²⁷ A mandatory response regime would ensure greater levels of accountability by placing responses on the public record, which would in turn increase the likelihood that coronial recommendations would be brought to the attention of department heads. According to the Committee, such a system would also place coroners' findings, comments and recommendations in the spotlight, ensuring a trend towards greater professionalism within the jurisdiction, while also providing coroners with the tools required to develop more effective recommendations. In addition, the responses would provide the data required for proper assessments of implementation rates and therefore of the effectiveness of the role of coroners. Finally, and importantly, by increasing levels of accountability, a mandatory response system would provide relief to grieving families who rightly demand systemic changes designed to avoid further deaths.²⁸

The Committee maintained that the ability of the coronial system to prevent death and injury would be substantially improved by the implementation of the accountability framework recommended by the Royal Commission into Aboriginal Deaths in Custody, particularly the mandatory response regime which has been adopted in different forms in the Australian Capital Territory, the Northern Territory and South Australia. The Committee considered that limiting an accountability framework to deaths in custody would be 'too tentative and difficult to justify on a public policy basis, given the number of deaths which occur in circumstances involving noncustodial agencies.'²⁹ Advancing the Northern Territory legislation as 'a working example of a mandatory response system that applies to non-custodial matters',³⁰ the Committee recommended incorporation into Victorian legislation of a mandatory reporting scheme applying to all coronial recommendations.³¹ Not only did the Committee consider that mandatory reporting should be required in relation to recommendations directed towards government departments and agencies, it considered that such reporting should extend to recommendations directed to incorporated companies and other private agencies, and to community organisations, peak organisations and individuals where appropriate.³² The Committee also recommended the inclusion of a summary of all cases in which recommendations had been made in an annual report by the State Coroner's Office to be tabled in Parliament and a monitoring system for compliance with coronial recommendations.³³ In March 2007 the Victorian Government indicated that it preferred voluntary cooperation between the State Coroner's Office

and government agencies to coordinate the consideration of and response to coronial recommendations rather than the mandatory legislative system recommended by the Committee.³⁴ In the result, the Coroners Bill 2008 (Vic), which came out of the Committee's review, contains no provisions relating to the consideration of and response to coronial recommendations by the agencies and organisations to whom they are directed.³⁵

III The Research Study

The study considered 185 coronial matters which produced 484 recommendations. The coronial matters and recommendations resulting from them considered by the study were identified from the National Coroners Information Service ('NCIS'),³⁶ from State and Territory Coroners' websites and from Coroners' annual reports.³⁷ In Victoria, New South Wales, South Australia and Western Australia the matters considered were those from the 2004 calendar year.³⁸ This timeframe was extended for Tasmania, the Northern Territory and the Australian Capital Territory due to the small number of coronial matters producing recommendations in these smaller jurisdictions in the year 2004.³⁹ As mentioned earlier, we obtained inadequate information about Queensland coronial recommendations and were therefore unable to include this jurisdiction in the study.⁴⁰ However, in 2006, after our study was completed, the Queensland Ombudsman published a report of a study which it had undertaken into practices relating to the implementation of coronial recommendations in that State. A summary of the Ombudsman's findings and recommendations relevant to our study is included later in this report.

Once the recommendations were identified, a letter of request was sent to the body or person to whom the recommendations were directed, seeking information about implementation of the recommendations.⁴¹ The letter of request asked, in summary: if the recommendation(s) had been implemented; if so, when the recommendation(s) was implemented; how the recommendation(s) was implemented; and if the recommendation(s) had not been implemented, why it had not been implemented. In a limited number of matters, in order to gain a more complete picture of organisational methods of processing and responding to coronial recommendations, requests were issued under freedom of information legislation requesting details of the communication of the recommendation, any discussion of the recommendation and any response to the recommendation.⁴²

The study received responses to the majority of inquiries it made about implementation of coronial recommendations. These responses were categorised as described below. In a number of cases no response was received to the inquiries made by our study about implementation of coronial recommendations from the entities responsible for their implementation.⁴³ Once responses and freedom of information requests were received, each recommendation was categorised as:

- implemented;
- partially implemented;
- not implemented;
- already in place at the time of the recommendation;
- not referred to in the response; or
- insufficient information provided in the response.⁴⁴

A recommendation was assigned to a particular category by an assessment process comparing the response to the text of the recommendation. Other external sources, including legislation, parliamentary debates, public policy documents, other coronial findings and recommendations and media reports, were consulted to assist with categorisation.

The study also carried out a number of case studies which undertook an exploration of factors affecting the implementation of coronial recommendations and an identification of failings in implementation processes. The case studies were compiled from the documentation provided by respondent organisations or obtained from them through freedom of information requests, and from the external sources mentioned above, including parliamentary debates and media reports. Often respondents did not explain why a recommendation had not been implemented. In such cases the external sources were relied upon to gain a better understanding of reasons for non-implementation.

Not all the case studies reported in our study have been included in this report. The case studies included are those which the authors believe best illustrate the variety of factors influencing implementation of recommendations and provide the clearest examples of the kinds of failings uncovered by the study in the organisational methods of processing and responding to coronial recommendations.

IV Data on the Implementation of Coronial Recommendations

A National Overview

As mentioned earlier, the study considered 185 coronial matters which produced 484 recommendations. The proportion of coronial recommendations implemented in the matters where responses were received by the study varied as follows:

- 27 per cent in Victoria;
- 41 per cent in Tasmania;
- 48 per cent in New South Wales;
- 50 per cent in Western Australia;
- 52 per cent in South Australia;
- 65 per cent in the Northern Territory; and
- 70 per cent in the Australian Capital Territory.

B New South Wales Data

The study investigated 24 matters in New South Wales in the 2004 calendar year, which produced 93 recommendations. Responses were received in relation to 47 of the recommendations. Of those 47 recommendations:

- 22 (48 per cent) were implemented;
- three (7 per cent) were already in place at the time of the recommendation;
- eight (17 per cent) were partially implemented;
- 11 (23 per cent) were not implemented; and
- two (4 per cent) did not have sufficient information provided to determine implementation.⁴⁵

Forty-five of the 93 recommendations investigated by the study contained recommendations directed to the Minister for Health, the Director-General of Health or the Chief Health Officer of New South Wales. No responses were received in relation to any of these 45 recommendations.⁴⁶

C Victorian Data

The study investigated 82 matters in Victoria in the 2004 calendar year, which produced 209 recommendations.⁴⁷ The study obtained information or received responses in relation to 138 of these 209 recommendations. Of these 138 recommendations:

- 37 (27 per cent) were implemented;
- 13 (9 per cent) were already in place at the time of the recommendation;
- 16 (12 per cent) were partially implemented;
- 23 (17 per cent) were not implemented; and
- 48 (35 per cent) either were not referred to in the response or did not have sufficient information provided to determine implementation.⁴⁸

Of the 71 recommendations for which no response or information was received, 42 of these concerned health matters, 22 concerned police and seven concerned other entities.⁴⁹

D South Australian Data

The study investigated 18 matters in South Australia in the 2004 calendar year, which produced 44 recommendations. The study received information in relation to 40 of these recommendations. Of these 40 recommendations:

- 21 (52 per cent) were implemented;
- two (5 per cent) were already in place at the time of the recommendation;
- six (15 per cent) were partially implemented;
- seven (18 per cent) were not implemented;⁵⁰ and
- four (10 per cent) did not have sufficient information provided to determine implementation.

E Western Australian Data

The study investigated 12 matters in Western Australia in the 2004 calendar year, which produced 34 recommendations.⁵¹ Responses were received in relation to 16 of these recommendations. Of these 16 recommendations:

- eight (50 per cent) were implemented;
- three (19 per cent) were partially implemented;
- three (19 per cent) were not implemented; and
- two (12 per cent) did not have sufficient information provided to determine implementation.

F Tasmanian Data

The study investigated 16 matters in Tasmania in the 2002, 2003 and 2004 calendar years, which produced 29 recommendations.⁵² Responses were received or information

obtained in relation to 27 of the recommendations. Of those 27 recommendations:

- 11 (41 per cent) were implemented (with three already in progress at the time the recommendations were made);
- three (11 per cent) were already in place at the time of the recommendation;
- three (11 per cent) were partially implemented; and
- nine (33 per cent) were not implemented.⁵³

G Northern Territory Data

The study investigated 24 matters in the Northern Territory in the 2003 and 2004 calendar years, which produced 65 recommendations.⁵⁴ Responses were received or reports obtained in relation to 63 recommendations. Of those recommendations:

- 41 (65 per cent) were implemented;
- three (5 per cent) were already in place at the time of the recommendation;
- seven (11 per cent) were partially implemented;
- six (9.5 per cent) were not implemented; and
- six (9.5 per cent) either were not referred to in the response or did not have sufficient information provided to determine implementation.

The Northern Territory is the only jurisdiction where coroners refer to the Indigenous status of the deceased in the text of their formal findings. Of the 24 matters for the 2003–04 period, 14 concerned Indigenous deaths, producing 36 recommendations. The remaining nine matters concerning non-Indigenous deceased produced 29 recommendations.

In relation to the 36 recommendations concerning Indigenous deaths:

- 21 (58 per cent) were implemented;
- two (6 per cent) were already in place at the time of the recommendation;
- three (8 per cent) were partially implemented;
- four (11 per cent) were not implemented; and
- six (17 per cent) either were not referred to in the response or did not have sufficient information provided to determine implementation.

In relation to the 29 recommendations arising from non-Indigenous matters, responses or reports were received in relation to 27 of the recommendations. Of those 27:

- 20 (74 per cent) were implemented;
- one (4 per cent) was already in place at the time of the recommendation;
- four (15 per cent) were partially implemented; and
- two (7 per cent) were not implemented.

H Australian Capital Territory Data⁵⁵

This study investigated nine matters in the Australian Capital Territory in the 2002, 2003 and 2004 calendar years, which produced 10 recommendations.⁵⁶ Of these 10 recommendations:

- seven (70 per cent) were implemented;
- two (20 per cent) were not implemented; and
- one (10%) did not have sufficient information provided to determine implementation.

In one of the seven recommendations characterised as implemented, we were advised that the relevant bodies had not been notified of the recommendation. It would therefore appear that this recommendation was coincidentally put into place.

I Queensland

As noted earlier, we were unable to obtain adequate information about Queensland coronial recommendations and were therefore unable to include this jurisdiction in the study. In December 2006, after our study was completed, the Queensland Ombudsman published a report of an investigation, the Coronial Recommendations Project ('CRP'), it carried out into the administrative practice of Queensland public sector agencies in assisting coronial inquiries and responding to coronial recommendations.⁵⁷ What follows is a summary of the relevant aspects of the Queensland Ombudsman's *CRP Report*.

The CRP arose out of a detailed investigation that the Queensland Ombudsman conducted into workplace electrocutions in Queensland, known as the Workplace Electrocution Project ('WEP'). The *WEP Report* examined the adequacy of the responses of government agencies to nine fatal electrical incidents between 1995 and 1999. Each of

those incidents was the subject of an inquest.⁵⁸ According to the Ombudsman, it became evident during the course of the WEP that, in many cases, little or nothing had been done by public sector agencies to assess and/or implement coronial recommendations designed to prevent deaths occurring in similar situations. To the Ombudsman's surprise, in a significant number of cases it was apparent that the relevant agencies had neither sought nor received a copy of the recommendations in question from the coroner and, in some instances, were unaware that recommendations had been made that concerned legislation they administered. Furthermore, where agencies were aware of recommendations and had agreed to implement them, there was no formal monitoring of the implementation of those recommendations by any independent entity. Accordingly, on most occasions, coroners and the families of the deceased were provided with no information as to what was being done by agencies to prevent a recurrence of the circumstances that had led to the fatal incident.

As a consequence, the Ombudsman decided to conduct an investigation to assess whether these problems evidenced the need for a coordinated system for ensuring that appropriate action was taken by public sector agencies in response to coronial recommendations. The CRP involved the analysis of 72 inquest reports prepared by Queensland coroners in 2002 and 2003 involving 23 agencies. The Project also considered the coronial inquests that were examined during the WEP.⁵⁹ Systemic problems that reduce the effectiveness of the coronial system in Queensland were reported by the Ombudsman, one of these problems being that no person or entity has the responsibility of monitoring whether public sector agencies properly consider and, in appropriate cases, implement coronial recommendations.⁶⁰ The Ombudsman also reported his view that, while the *Coroners Act 2003* (Qld) has satisfactorily addressed the communication of coronial recommendations to agencies, issues surrounding the formulation and implementation of recommendations remain problematic.⁶¹

According to the Ombudsman, his audit showed that, amongst other things, a significant reason for public sector agencies not implementing coronial recommendations is that the relevant agency considers that the recommendation is not soundly based or is not practicable,⁶² and that the effectiveness of the coronial system is reduced by the fact that public sector agencies to which coronial recommendations are directed are not required to respond to those recommendations.⁶³

The Ombudsman made a series of recommendations for amendments to the *Coroners Act 2003* (Qld). Amongst other things, the Ombudsman recommended an amendment to require that, where an agency has been notified by a coroner of a relevant coronial recommendation, the agency must, within six months of the notification, advise the coroner of the action taken or proposed to be taken to implement the recommendation or, if the agency does not intend to take action, its reasons for not doing so.⁶⁴ The Ombudsman recommended that the response of public sector agencies to coronial recommendations should be monitored and indicated his view that the Queensland Ombudsman is best placed to undertake this monitoring role.⁶⁵ The Ombudsman also recommended that public sector agencies (particularly those frequently involved in inquests) should appoint coronial liaison officers.⁶⁶

V Case Studies

The data collected by our study indicated that a number of factors may affect implementation of coronial recommendations. These factors include:

- the feasibility of a coronial recommendation;
- whether or not implementation of a recommendation accords with government policies and priorities;
- the manner in which a recommendation is formulated or expressed by a coroner;
- the manner in which a recommendation is distributed or communicated by a coroner;
- whether or not a pro-active system for review of recommendations exists within the organisation to whom the recommendation(s) is directed;
- whether or not a mandatory system of reporting organisational responses to recommendations is in place;
- whether or not prior coronial recommendations arising out of similar deaths are drawn to the attention of relevant authorities by coroners or others;
- whether or not an inquest and its recommendations attract media attention; and
- whether or not some form of public advocacy accompanies the recommendation.

The case studies below reveal successes and failures in the coronial and governmental processes attaching to the implementation of recommendations, and illustrate

other factors influencing the implementation of coronial recommendations.

A Process Successes

1 Mandatory Reporting

The data and the case studies show clearly that a mandatory reporting scheme provides an effective process through which coronial recommendations are communicated and responded to by responsible government agencies. As discussed before, the Northern Territory is the only jurisdiction in Australia that requires government agencies to respond to all coronial recommendations and for the tabling of such responses in Parliament. In the Northern Territory, unlike in other jurisdictions, there were no matters identified in the study from the 2003 and 2004 calendar years in which coronial recommendations were not communicated to the relevant government agency or were lost or neglected within a government agency. It may be that mandatory reporting is also a factor in implementation of coronial recommendations. In the data collected by the study, the Northern Territory achieved one of the highest rates of government agency implementation of recommendations.

2 Government Agency Internal Systems for Review of and Response to Coronial Recommendations: The WA Department of Health

The Western Australian Department of Health is an example of a government agency with an internal system for the review of and response to coronial recommendations. As discussed previously, the study investigated 12 matters in Western Australia in the 2004 calendar year, which produced 34 recommendations. Four of these inquests and eight of these recommendations concerned the Western Australian Department of Health. The Department responded to all of the inquiries made by the study about these recommendations and provided the study with evidence that all of the coronial recommendations directed to it had been seriously considered. Of the eight recommendations directed to the Department:

- five were implemented;
- two were partially implemented; and
- one was not implemented.

The only coronial recommendation not implemented by the Department of Health was considered by the Department to be beyond its jurisdiction.

The Western Australian Department of Health contains an Office of Safety and Quality in Health Care ('OSQH'). This office was established in 2002 and provides advice to the Minister of Health and the Department of Health on safety and quality issues.⁶⁷ That office has established a Coronial Liaison Unit, which incorporates into its processes lessons learned from coronial findings and recommendations. Coronial findings concerning health are now published at the OSQH section of the Department's website. (Three of the four matters considered in this study were published on that site.) In addition, in the 2004 and 2005 calendar years a new process was developed for consideration of coronial recommendations, including a flow chart demarcating the lines of responsibility for action on coronial recommendations and who must be advised of the recommendations and proposed action.⁶⁸

The culture, policies and practices of the Western Australian Department of Health appear designed to encourage serious and effective consideration of, and responses to, coronial recommendations.

B Process Failures: Coronial Recommendations Lost, Neglected or Not Communicated

In contrast to the situation in the Northern Territory and the Western Australian Department of Health case study, the following case studies reveal failures in the processes attaching to the implementation of coronial recommendations. In these cases, drawn from New South Wales, South Australia, Tasmania and the Australian Capital Territory, coronial recommendations were either not communicated to the government agencies responsible for their implementation, or were lost or otherwise neglected by those agencies.

1 New South Wales Case Studies

A number of New South Wales case studies reveal coronial recommendations that were not communicated to the bodies to whom they were directed, or were lost or otherwise neglected by the New South Wales government agencies responsible for their implementation. In some cases, active consideration of coronial recommendations may only have been prompted by our study's request for

information concerning implementation of a particular recommendation(s). In five government areas in New South Wales, namely, health, housing, energy, fair trading and police, the case studies reveal significant problems with government organisations responding to coronial recommendations. All matters investigated by the study in New South Wales were matters in which recommendations were made in the 2004 calendar year.

(a) New South Wales Health

In 2004 a number of coronial recommendations arising from deaths involving health care were made and directed by coroners to either the Director-General of the Department of Health, the Minister for Health or the Chief Health Officer of New South Wales. We inquired about the implementation of these health-related recommendations with the appropriate health authorities in early November 2005.⁶⁹ After our inquiries, the New South Wales Department of Health wrote to the New South Wales Coroner's Office and informed the New South Wales Coroner's Office that:

the newly created Corporate Governance and Risk Management Branch of the NSW Department of Health has recently taken over the role of co-ordinating dissemination and follow up of recommendations from coronial reports.⁷⁰

The Department's letter to the State Coroner goes on to indicate that it appeared that reports had not been received in two of the matters which our study had inquired about. The findings in these matters, one concerning a death in the course of a police pursuit and the other a workplace suicide, were handed down in August and November of 2004. The recommendations in these two matters were subsequently forwarded by the Coroner's Office to the relevant health authorities in early 2006.

(b) New South Wales Housing Commission

In this case, a Housing Commission tenant had died in Housing Commission premises and the tenant's body had remained undetected for over two and a half years. In May 2004, after an inquest into the death, the Deputy State Coroner recommended that the Department of Housing take action, such as 'follow-up' visits by client service officers, to ensure earlier detection of Housing Commission deaths. Our study revealed that, almost a year and a half after the Coroner made this recommendation, the Department responsible for

its implementation remained unaware of it. Following the issuing of a freedom of information request to the Department seeking documentation related to the recommendation, including the notification from the Coroner's Office and internal and interdepartmental communication about the recommendation, the Department advised that it did not hold the records we sought. Indeed, it appeared that the responsible Department only became aware of the recommendation as a result of our inquiries.⁷¹ Either the Coroner failed to properly communicate this recommendation to the responsible Department or the Department failed to keep a proper record of the recommendation properly communicated by the Coroner.

(c) New South Wales Department of Energy, Utilities and Sustainability and the Office of Fair Trading

On 9 August 2004, findings were brought down by the Deputy State Coroner, Dorelle Pinch, in relation to the deaths of two women killed when they were electrocuted in their units due to an electrical fault. The Deputy State Coroner made the following recommendation addressed to the 'Minister for Energy':

[That] Energy Suppliers and appropriate government organisations determine and implement the best way of educating the public about:

1. the installation of safety switches on lighting circuits as a desirable safety measure to prevent electrocution;
2. the use of a detection device to locate electrical wiring prior to inserting nails in floor, wall and ceiling surfaces as a desirable safety measure to prevent electrocution.⁷²

Following our forwarding a letter to Carl Scully, the then Minister for Utilities, on 4 November 2005 inquiring into the implementation of these recommendations, we received a response from the Department of Energy, Utilities and Sustainability, dated 23 November 2005, advising that the matters were under consideration and that we would receive a reply as soon as possible. We received a further reply from the Parliamentary Secretary for Utilities, dated 19 December 2005, which advised that the recommendations were primarily the responsibility of the Minister and Office of Fair Trading. In response to a freedom of information request to the Office of Fair Trading in March 2006 seeking documentation relating to notification, communication and

implementation of the recommendations, we were advised by the Office in April that no such documents were held. Soon after, the Minister for Fair Trading sent us a letter, which said that the Department of Energy, Utilities and Sustainability had referred the matter for consideration to the Industry Safety Steering Committee in December 2005 (which was, as it happened, after we had initially contacted that Department).⁷³ According to the Minister's letter, the Office of Fair Trading was awaiting the Steering Committee's advice.

It appears that the Deputy State Coroner's recommendations in August 2004 for safety measures to prevent electrocutions fell onto uncertain ground as to whose responsibility they were for follow-up. In the absence of any apparent system for follow-up or reporting, the safety recommendations appear to have remained in limbo, at least until our letter inquiring about the recommendations.

(d) New South Wales Police

Five New South Wales inquests examined in this study produced recommendations directed to the New South Wales Police – either to the Minister for Police, or to the Commissioner for Police. Those inquests concerned:

1. a death in a police car chase – recommendations were made on 1 July 2004 to the Commissioner of Police;
2. a death by suicide of a mental health patient – recommendations were made on 26 August 2004 to the Minister of Police and the Commissioner of Police;
3. an industrial death – recommendations were made on 19 November 2004 to 'NSW Police';
4. a death by self-inflicted stabbing in the course of a police pursuit – recommendations were made on 29 November 2004 to the Minister of Police and the Commissioner of Police; and
5. a death by drowning where the person had been reported missing – recommendations were made on 14 December 2004 to the Minister of Police and the Commissioner of Police.

Following correspondence in November 2005 between us, the Commissioner of Police and the Assistant Commissioner of Professional Standards in relation to Inquest 1, we were informed of the state of implementation of the recommendations coming out of that inquiry. For Inquests 2–5, however, the process of obtaining information about the

responses to and implementation of recommendations was more complex, as the following timeline shows:

- 8 November 2005: letter sent by us to the Commissioner of Police seeking information about the implementation of recommendations in Inquests 2–5.
- 25 November 2005: email sent by us to the Minister for Police seeking information as to the implementation of the recommendations in Inquests 2, 4 and 5.
- 25 November 2005: the New South Wales Police write to the Coroner in response to the recommendations in Inquest 5. Letter not forwarded to Coroner due to administrative error.⁷⁴
- 20 December 2005: the Assistant Commissioner of Professional Standards indicates he is unable to respond to our inquiries and suggests we contact the State Coroner's Office, 'who received all of NSW Police's formal responses to coronial matters involving police'.⁷⁵
- 21 December 2005: the Assistant Commissioner of Professional Standards writes to the Coroner in response to the recommendations in Inquest 3.
- 24 January 2006: the New South Wales Police write to the Coroner in response to the recommendations in Inquest 4. Letter not forwarded to Coroner due to administrative error.⁷⁶
- 17 February 2006: the New South Wales Police write to the Coroner in response to the recommendations in Inquest 2.
- 8 June 2006: the Police responses in relation to Inquests 4 and 5 forwarded to the Coroner.

Given that it had been at least a year between when the recommendations were made in Inquests 2–5 and when the New South Wales Police responses were finally received by the Coroner, and that these responses came after our inquiries to the Commissioner and Minister as to the status of those responses, the timing of these events raises the possibility that the police responses to these coronial recommendations were prompted by our inquiries. Weight is added to this possibility by the particular circumstances of Inquest 3. In that inquest, concerning an industrial death, one of the recommendations was for the New South Wales Police to examine the protocol between the Police and WorkCover relating to industrial death investigation. Our letter of inquiry was sent on 8 November 2005 and acknowledged on 22 November 2005. A response to the recommendations, indicating that the protocol had been examined on 8 November, was sent by the Commissioner

of Police to the Coroner's Office on 21 November 2005. In the circumstances, it seems reasonable to conclude that our letter may have prompted the Commissioner's response to the Coroner. In relation to that same inquest, we had a similar experience with New South Wales WorkCover and the Minister for Commerce and Industrial Relations, whose responses to the relevant recommendations came only after we made inquiries, and over a year after the recommendations were originally made.⁷⁷

2 South Australian Case Study

On 16 July 2004 the South Australian State Coroner brought down his findings and recommendations in relation to a homicide/suicide, where the perpetrator was known to be mentally ill. In the course of his findings, the Coroner discussed the importance of an updated Memorandum of Understanding ('MOU') between the South Australian Police and Mental Health Services in relation to their management of threats of violence, the Coroner ultimately recommending that the South Australian Police and Mental Health Services execute and implement an updated MOU without delay. The South Australian Director of Mental Health in the Department of Human Services, Dr Jonathon Phillips, provided a written response to the Coroner's recommendations on 10 March 2005. In relation to this MOU recommendation he advised:

The MOU has been signed off by all parties except the South Australia Police (SAPOL). It is currently with SAPOL for consideration and sign-off. Once this has occurred, roll-out of the MOU will be progressed.⁷⁸

We wrote to the South Australian Commissioner of Police on 9 November 2005 seeking information as to the implementation of this recommendation. We received a response dated 2 February 2006, which advised:

In 2000 South Australia Police (SAPOL) established a Memorandum of Understanding (MOU) with Mental Health Services of the Department of Human Services in relation to service response to mental health issues. SAPOL is currently reviewing that MOU as part of the continuous improvement process.⁷⁹

On 16 March 2006 we again wrote inquiring about the cause of the delay in the implementation of the Coroner's recommendation. We received the following response:

There has been no delay in implementing the recommendation of Coroner Chivell as an MOU formed in 2000 was at that time and remains in operation; however, as I mentioned in previous correspondence, a review of that arrangement is being conducted.⁸⁰

The Coroner's recommendation of July 2004 called for a revised MOU to be executed and implemented without delay. Mental Health Services expressed the view that all parties other than the Police had signed off on the MOU, but the Police were of the view that they had signed off on the MOU. There is clearly no meeting of minds in relation to the 'understanding'. The Coroner's recommendation has not been brought into effect.

3 Tasmanian Case Study

On 11 September 2003 the Tasmanian Coroner brought down findings in an inquest into the death of a child who had drowned in a backyard pond. He commented that, despite the existence of building regulations relating to swimming pools and spas, the relevant legislation fails to address the potential dangers of ponds, and recommended that the legislative oversight be addressed at a local and national level. The recommendation was forwarded to the Tasmanian Police, KidSafe and the Department of Premier and Cabinet. After we contacted the Department of Premier and Cabinet, they advised that they had no record of receiving the recommendation, but that the relevant legislation and regulations had ceased to be the Department's responsibility prior to the Coroner's findings; they were now the responsibility of Workplace Standards Tasmania. On inquiry with Workplace Standards Tasmania, we were advised that they too had not received the recommendation, and further that swimming pool/pond fencing requirements are governed by the National Building Code of Australia, with the Australian Building Codes Board being the responsible body. As the trail of correspondence demonstrates, there appears to have been a breakdown in the communication of the recommendations in this child drowning inquest.

4 Australian Capital Territory Case Studies

(a) Minister for Urban Services

On 24 October 2003, following a motor vehicle death inquest, the Australian Capital Territory Coroner recommended that the Minister for Urban Services consider introducing

legislation requiring that lap-sash seatbelts be retrofitted to vehicles without seatbelts. We wrote to the Minister for Urban Services on 14 December 2005, seeking advice in relation to the implementation of the recommendation. In a reply dated 8 February 2006, the Minister advised that

no formal consideration of retro-fitting seat belts in vehicles has been undertaken as a result of the recommendation of the Coroner. However, a number of national considerations about retro-fitting seatbelts have been in progress ...⁸¹

In his letter, the Minister went on to detail a review being undertaken by the Australian Road Rules Maintenance Group. A search of the Department of Urban Services' website revealed a media release dated 30 January 2006 advising of the review by the Australian Road Rules Maintenance Group and encouraging public comment to the review.⁸² The media release indicated that comments were to close on 3 February 2006. Given the date of our initial inquiry (14 December 2005), the short time frame between the issuing of the media release calling for public comment on the review and the date for close of comments (30 January to 3 February 2006), and the subsequent reply to our correspondence from the Minister (8 February 2006), it may be that our inquiry prompted Ministerial investigation of the recommendation. Alternatively, it may be coincidence.

(b) ACT Health

Another Australian Capital Territory inquest concerned the death of a mentally ill woman in a house fire. The Coroner in that inquest recommended that the Government consider wiring smoke detectors in government-owned premises back to a monitored base. Although the deceased woman was not at the time of her death resident in a psychiatric hospital, she was subject to an involuntary psychiatric treatment order under the *Mental Health (Treatment and Care) Act 1994* (ACT). Under s 3C(1)(e) of the *Coroners Act 1997* (ACT), deaths involving persons subject to orders under the *Mental Health (Treatment and Care) Act 1994* (ACT) are classified as deaths in custody.

Coronial recommendations arising out of deaths in custody should trigger the operation of compulsory reporting provisions. These require that the coroner report the findings to the responsible custodial agency and Minister, and to the Attorney-General, amongst others.⁸³ Further provisions also require that the responsible custodial agency give the

III The Coroner's Exercise of Discretion

While a more detailed discussion of two specific exercises of discretion by the Coroner is given below, there were a number of other instances where the Coroner exercised her discretion in a way that, although open to her and not improper, distressed the Elder's family. This was because it was not clear to them whether the Coroner had taken into account their concerns, or for what reasons the Coroner decided not to exercise her discretion in their favour, as reasons were not provided to the family. These included:

- the Coroner's refusal or failure to provide the Elder's family with various documents referred to both in the inquest brief and by witnesses during the giving of their evidence, despite the family's repeated requests;⁷
- the Coroner's acceptance into evidence of, without inviting submissions from the family as to the relevance of and weight to be attributed to, a report into the Elder's death that had been commissioned by the Katherine West Health Board and the Northern Territory Department of Health, notwithstanding the family raising concerns with the Coroner about the report's relevance and independence;⁸
- the Coroner's rejection of the family's requests⁹ for further investigations into relevant matters that had not been fully explored or explored at all (eg, the existence of guidelines for District Medical Officers, records of plane arrivals at the Kalkarindji community);
- the Coroner's failure to call as witnesses the police who conducted the search for the Elder, despite the Coroner initially accepting the family's request that these witnesses be called in order to ascertain the adequacy of the search;¹⁰ and
- the Coroner's refusal, without giving reasons, of some of the family's requests¹¹ for additional witnesses to be called.

I now turn to the two exercises of discretion by the Coroner that had the most distressing and substantial impact on the family.

A Location of the Inquest Hearing

1 How the Coroner Exercised Her Discretion

The issue of what was the appropriate location for the inquest first arose in May 2007. At that time, the Coroner¹² advised

the family¹³ that the inquest would be held between 13 and 16 November 2007 in Katherine. The family of the Elder wanted the inquest to be held in Kalkarindji because they considered that:

- it would be respectful to the Elder and to his family, and would serve as a recognition of the status and importance of the Elder in the community;
- Kalkarindji was the place where he had passed away;
- it would enable the family and the rest of the community to attend the hearing and, where relevant, give evidence;
- it would give the family and the rest of the community a chance to say their personal goodbyes to the Elder and gain closure;
- it would be in the interests of justice and good public policy.

The family therefore formally requested that, at the very least, two days of the inquest be held in Kalkarindji.¹⁴ The family indicated that they were very keen for this to occur.

In June 2007 the Coroner advised the family that only the first day of the inquest would be held in Kalkarindji and gave no reasons why it was not possible for at least two days of the inquest to be held in Kalkarindji.¹⁵ On 25 October 2007 I telephoned the Coroner's office and also sent an email to the Coroner's office, requesting a return telephone call. I did not receive a return telephone call. The following day I telephoned Counsel Assisting the Coroner to discuss the logistics of the inquest. I indicated that the family and the community preferred the inquest to be held in Kalkarindji and that it was more respectful for the community for the inquest to be held in Kalkarindji. I was informed that the matter required further consideration. The family then again requested that the Coroner hold a minimum of two days of the inquest in Kalkarindji, while still indicating that the preference was for the whole of the inquest be held in Kalkarindji.¹⁶ The Coroner did not respond to the family's request.

Approximately a month later, on 30 November 2007, I telephoned Counsel Assisting the Coroner, again to discuss the logistics of the inquest, and advised him that it was not going to be possible for the family to travel overnight from Kalkarindji to Katherine. The family then sent a further letter to the Coroner stating:

We note that 75 per cent of the inquest is to be held in Katherine. We find this disappointing, particularly given that the old man died in Kalkarindji, his family lives in Kalkarindji and that the broader community in Kalkarindji has an interest in the outcome of the inquest. We consider that in terms of providing access to justice and for public policy reasons it would be more appropriate for at least half of the inquest to be held in Kalkarindji.¹⁷

The Coroner did not respond to this letter. In the end, only the first day of the inquest (13 November 2007) was held in Kalkarindji. The remainder of the inquest was held in Katherine.¹⁸

2 Impact on the Family

The Coroner's decision not to hold the entire inquest in Kalkarindji had a significant impact on the family. As the family wanted to attend the whole of the inquest, they were forced to travel from their home and the place where they felt most comfortable to Katherine. The logistics of transporting the family and community members, along with their legal representatives and an interpreter, from Kalkarindji to Katherine by road overnight (bearing in mind that the journey by road takes in excess of five hours) posed no mean feat. The family had no means of road transport and could not afford to charter a plane to Katherine. In addition, the family did not have any accommodation in Katherine. As things transpired, the North Australian Aboriginal Justice Agency ('NAAJA') chartered a bus, found a bus driver and arranged accommodation. NAAJA is a legal aid organisation with limited funding, and it is subject also to restrictions with regard to its funding arrangements. NAAJA was required to bear the costs of the travel, accommodation and all incidentals, such as food, which added up to a substantial amount.

The family could not understand the Coroner's decision not to hold the inquest in Kalkarindji and, further, could not understand why she had not even provided them with responses to their requests or explained to them why the inquest could not be held in Kalkarindji. They pointed out to me that they had travelled over six hours on a bus, without air-conditioning, in high temperatures, just to be present at the inquest, while the Coroner had flown on a plane and had no idea what the journey to Katherine had been like for them.

The family was also unhappy that the people from the Daguragu and Kalkarindji communities were not able to watch the 'Coroner's business'. They also felt that some members of the community were not given sufficient opportunity to present their views on what had happened to the Elder to the Coroner because they were not in the community on the first day of the inquest and were not able to travel to Katherine to be present for the remainder.¹⁹

3 Comments

I consider that, in the circumstances of this case, the Coroner should have held the inquest into the Elder's death in Kalkarindji.²⁰ There may have been good reasons behind the Coroner's decision not to do so, and the Coroner probably took various considerations, such as availability of accommodation and the location of the other witnesses, into account in making her decision. However, those reasons and considerations were never communicated to the family. Consequently, the family was left wondering whether the Coroner had even considered their request and, if their request was considered, what factors the Coroner had regard to in making her decision and what weight she gave to those factors. The family was offended by what they thought was a failure by the Coroner to communicate adequately with them.

B Interpreter in the Inquest

1 How the Coroner Exercised Her Discretion

Shortly prior to the inquest, the family contacted the Coroner to ascertain the identity of the interpreter the Coroner had organised to be present at the inquest, and to confirm that the interpreter spoke the correct language. Two family members were going to be giving evidence, and the family had presumed that the Coroner would organise an interpreter for them²¹ so that they could give their evidence in their native language, Gurindji. The family also thought that the interpreter would then be present in the room in order to translate the proceedings for them. However, the family was informed that no interpreter had been arranged and, in fact, no thought had been given to the need for an interpreter.

In a letter to the Coroner, the family stated:

As a courtesy to the Coroner, we confirm that we will organise for an interpreter fluent in the Gurindji language (the language spoken in the Kalkarindji area) to be present

at the inquest. However, we consider it the responsibility of the Coroner's office to pay for and transport the interpreter ... [We request that you] provide us with confirmation that the Coroner's office will pay for the interpreter and arrange his or her transportation.²²

Following this letter, the Coroner advised the family that an interpreter had been organised for the inquest. However, the Coroner later advised the family that funding for an interpreter would only be supplied for the first day of the inquest, as the Coroner considered that that was the only day an interpreter would be required.

It came to the family's attention, after several inquiries with the Katherine Language Centre, that the Coroner had not confirmed with the Centre that an interpreter was needed for the inquest. An email to the Coroner sent on 9 November 2007 stated:

Can you please confirm you actually have an interpreter booked for Tuesday who speaks the Gurindji language and who that person is? We were told yesterday by the Language Centre that an interpreter has not yet been found.²³

The Coroner did not respond.

On the first day of the inquest an interpreter was present. Counsel Assisting advised the Coroner that: 'It seems that four of our witnesses ... from what I could detect they're more comfortable in Gurindji and ... we do have an interpreter here and she can interpret as and when necessary.'²⁴ The first witness called to give evidence was the Elder's son. Counsel for the family requested that the interpreter assist the Elder's son to give his evidence. As the interpreter began translating the questions, it became clear that the interpreter was not speaking in Gurindji.²⁵ Counsel for the family confirmed this with the interpreter. The interpreter that the Coroner had organised was a Kriol speaker,²⁶ whereas the witnesses the interpreter was translating for were Gurindji speakers.

2 Impact on the Family

The family was disappointed by the Coroner's decision to fund an interpreter for only the first day of the inquest. Given that the family's main language is Gurindji and the proceedings were conducted in English, there was the potential for the family to not fully understand what was happening. The family felt, rightly or wrongly, that the Coroner was in a

better position to bear the cost of an interpreter than they were. Ultimately, the family did arrange its own interpreter for the inquest.²⁷

The family's feelings were compounded when it transpired that the Coroner had arranged a Kriol interpreter rather than a Gurindji interpreter. Although the Elder's son, who understands some Kriol, was able to give his evidence with the assistance of the Kriol translator, that process was not an easy one. The Elder's son had to try to translate the questions from Kriol into Gurindji in order to understand them, and he would then have to translate his answers from Gurindji to Kriol. The family felt that having an interpreter in the wrong language meant that there was the potential for the evidence being given to be distorted. In addition, they felt that it showed a lack of understanding of the need to ensure that the correct interpreter for the particular circumstances is chosen.

3 Comments

I respectfully submit that, in the circumstances of this case, the Coroner should have funded an interpreter for the family for the duration of the inquest in order to ensure that they understood the proceedings. In addition, the Coroner should have ensured that the interpreter that was ultimately chosen was able to speak the correct language. Again, there may have been good reasons behind the Coroner's decision not to make an order that the Court fund an interpreter for the family and to provide a Kriol interpreter, and the Coroner probably took various considerations, such as the cost and availability of the interpreters, into account in making her decisions. However, those reasons and considerations were never communicated to the family.

IV Guidelines

A The Need for Guidelines

I respectfully submit that the family's experience of the inquest could have been less traumatic had the Coroner exercised her discretionary powers in the manner requested by them or, alternatively, provided the family with a formal response outlining the reasons why she was not prepared to exercise her discretion as requested by them. I therefore consider that, in order to avoid similar situations arising in the future, there is a need for guidelines to be implemented in relation to how the coroner should exercise his or her discretion in relation

to particular aspects of the coronial inquest procedure. These include, but are not limited to, the location of an inquest and the use of interpreters during an inquest.

Guidelines would also be beneficial for other reasons. First of all, they would improve consistency in coroners' exercise of their discretionary powers, which in turn would lead to greater transparency. Additionally, they would give family members of the deceased in coronial inquests a greater idea about how the inquest will run and how their requests will be determined.

B Content of Guidelines

In my respectful opinion, guidelines for coroners in relation to the exercise of their discretion should contain a general guideline to the effect that, where the family requests that the coroner exercise his or her discretion in a particular manner, it is the coroner's responsibility to give serious consideration to the request and, where possible, grant the request, provided that the request is reasonable and made with good reason. Furthermore, the guideline should stipulate that, in the event that the coroner determines not to grant the request, the family must be given clear reasons why their request will not be granted.

For Indigenous Australians, the land and community where they live is particularly important, as it represents the core of their spirituality and is fundamental to their wellbeing. I therefore consider that, in relation to the location of the inquest into the death of an Indigenous person, the following matters should be contained within the guidelines:

- (a) preference should be given to holding the whole of an inquest in the community of the person who has passed away.
- (b) if, in the exercise of his or her discretion, the coroner determines that it is not possible for the whole of an inquest to be held in the community of the person who has passed away, the coroner must consider and weigh up the following factors:
 - the location of the other witnesses and the availability of telephone and video conference facilities;
 - availability of accommodation;
 - what travel arrangements the family will need to arrange in order to be present at the inquest;

- the broader community interest in the inquest; and
- the interests of justice and any relevant matters of public policy.

- (c) if it is not possible for the whole of the inquest to be held in the community of the person who has passed away, then some of the inquest should be held at that place, and the coroner should explain to the family, either in writing before the commencement of the inquest, or orally at the beginning of the inquest, why the coroner determined that it was not possible for the whole of the inquest to be held at that place.

I consider that the above guidelines strike an acceptable balance between ensuring that the needs and wishes of the family and broader community are met and the practical considerations.

In my opinion, it is in the interests of justice to allow all witnesses at a coronial inquest to speak with the aid of an interpreter if English is not their first language. The coroner should therefore exercise his or her discretion to allow an interpreter for all such witnesses. A rudimentary understanding of the English language may not be sufficient to allow a witness to fully comprehend the questions he or she is asked and form the necessary response. There is a wealth of evidence available in support of this submission²⁸ that makes it, in my respectful opinion, entirely unacceptable for a coroner to refuse an interpreter for a witness whose first language is not English.

I therefore consider that it would be appropriate to include the statements to the following effect in guidelines for coroners as to the exercise of their discretion:

- when requested to do so, the coroner must, unless it is impractical or impossible to do so, provide an interpreter for a witness in the language requested by that witness;
- when requested to do so, the coroner must, unless it is impractical or impossible to do so, provide an interpreter for the family of the person whose death is being investigated, in the language requested by the family; and
- if the coroner determines that it is impractical or impossible to provide an interpreter in either of the circumstances mentioned above, the coroner must

explain to the witness or family, in writing before the commencement of the inquest, why the coroner determined that it was impractical or impossible to provide an interpreter.

While I do not outline a complete set of guidelines in this article, in my opinion a complete set of guidelines would need to make provision for other matters that coroners are required to exercise their discretion in relation to. These matters include the entitlement of families and other interested parties to receive copies of relevant documents, and requests by families and other interested parties that certain documents be produced to the coroner for his or her consideration.

V Submissions, Recommendations and Findings

A Relevant Circumstances Concerning the Death

The family submitted to the Coroner that each of the following circumstances directly related and contributed to the death of the Elder.

1 Failure to Provide an Escort

The Elder satisfied the PATS guidelines for receipt of an escort and was therefore entitled to receive an escort on three separate occasions: when he was flown from Kalkarindji to Katherine Hospital; when he was in Katherine Hospital receiving treatment; and when he was discharged from Katherine Hospital and flown to the Kalkarindji community.²⁹ Despite the Elder's entitlement to receive an escort in those three situations, none was provided. Dr Buchanan overrode the nurse's recommendation and advocacy in favour of an escort for the Elder.³⁰ Despite his entitlement to receive an escort on three separate occasions, the Elder was not properly assessed in relation to his need for an escort at any time.³¹

In relation to the provision of an escort, the Coroner found that the Elder, by virtue of his age, frailty, deafness and language difficulties, undoubtedly qualified under the PATS guidelines for an escort. There was, however, confusion as to the guidelines' operation, the Coroner noted. She stated:

[The Elder] should have been accompanied by an escort for his safe transport and hospitalisation. That need should have been met on transfer out of his community but could also

have been identified and met either during hospitalisation or on discharge. ... It would have been appropriate for the Clinic at Kalkaringi to follow up to the escort situation the following day and it would be, in my view, good practice for the Clinic to have in place a system for escort review when patient transfers have occurred out of hours to ensure that if an escort was warranted and for some reason did not eventuate, that further steps then be taken to advocate for an escort for hospitalisation and/or repatriation.³²

The Coroner noted that the Elder's stepdaughter would have been a suitable escort, and that she was 'deeply distressed that she had been unable to fulfil her role of caring for her stepfather during his illness and treatment and assist his safe return'.³³

2 Failure by Pilot to Make Contact

In his evidence, the pilot conceded that he could have used his CDMA telephone to contact the PATS department at Katherine Hospital, the Kalkarindji clinic or the Daguragu Community Council to advise that the Indigenous Elder had arrived back in the community.³⁴ In relation to the pilot, the Coroner found the following:

[The pilot] knew the distance from the airstrip to Kalkaringi. He had a phone and the telephone number of the Clinic. It was still early afternoon when staff would have been present. There could not have been any anxiety about the need to take off because of failing light. It may not have been part of his contractual obligations to ensure that passengers were picked up and it may have been that he had been directed by his employer to do nothing other than his flight duties. It may be that he assumed that as there had never been a problem in the past, someone would eventually arrive to pick up [the Elder]. However his actions in simply depositing an elderly frail man returned from a hospitalisation at the most basic of facilities at the airstrip when he might just as easily make a quick call to the Clinic or to the Patient Travel Office in Katherine, lacked the most basic element of human compassion. [The Elder] was not a parcel to be deposited for someone to collect. Respect for his age and situation, would it may be hoped have caused most people to make that call to assist him. That telephone call to the Clinic would almost certainly have altered the outcome for [the Elder]. It was not an omission that caused his death, but it might well have prevented it.³⁵

3 Police Search and Date of Death

The Elder's body was found on Monday 28 August 2006. Between 24 August and 27 August helicopter searches passed directly over the place where the Elder's body was found, and foot searches passed close to, and apparently within eyesight of, the place where the Elder's body was found. The country where he was found was relatively open and the Elder's clothing was visible.³⁶ There was no evidence before the Coroner challenging the integrity of the police search. Counsel Assisting the Coroner called no evidence to suggest that those people involved in the search could have, but failed to, see the Elder at the place where his body was found. Therefore, the only conclusion is that, during the police search, the Elder was still alive and mobile, and was not in the location where he was ultimately found. There is evidence in support of the proposition that the Elder walked between five and 10 kilometres before he passed away and that he had died not more than three days before being found.³⁷ In line with this evidence, and the evidence of the police search, it was contended by the family that the Elder passed away either on 27 August or on a date unknown between 24 and 27 August. The family argued that any forensic evidence to the contrary, inconsistent with evidence of the police search, should be rejected. However, in her findings, the Coroner rejected this submission, stating:

There is no support on the evidence for the proposition advanced by Counsel for the Family and I find that [the Elder] passed away no later than Wednesday evening 23 August 2006, which may be noted was prior to the search commencing.³⁸

4 Patient Travel Facsimile Transmission to Kalkarindji

The family argued that there was insufficient evidence to establish that the Katherine Hospital PATS department notified the Kalkarindji clinic by facsimile transmission on Friday 19 August 2006 or at all about the planned return of the Elder to Kalkarindji. Furthermore, they argued that there was no evidence that anyone at the Kalkarindji clinic did any act, or omitted to do any act, that in any way contributed to the death of the Elder.

In relation to this matter, the Coroner found the following:

The weight of the evidence supports the view that the fax was sent to Kalkaringi on 18 August 2006, advising of [the

Elder's] travel on the Monday. Ms Sheals and the other staff at Patient Travel [at Katherine Hospital] had a very set routine as to how they arranged and advised of the travel. There is no reason why she would depart from these long established procedures on this occasion. Her evidence of sending the fax is supported by the records for those phone lines. No fault with the fax machine at Kalkaringi has been identified.

The Clinic had a system for dealing with faxes that advised of return Patient Travel which may, at the least, be described as haphazard. ...

The system for return Patient Travel was defective from the Hospital end as well. ... [T]he system of sending faxes to advise of travel relied on an assumption that one having been sent to a Clinic, that it would be received and acted upon. ...

There was no system check to ensure that such communications had been received by Clinics. ... That the system had worked without fatal incident led to an assumption and complacency that the system worked well and efficiently but in truth, it was almost inevitable that what occurred with [the Elder] would happen at some point in time.³⁹

5 Comments

In conclusion, the Coroner found that the Elder's death was a 'preventable death and a tragedy'.⁴⁰ I agree with this statement. The Coroner's findings generally support the proposition that the systems in place failed the Elder and led to his untimely death.

B Recommendations

The family of the Elder requested that the Coroner make the following recommendations to the Attorney-General.

Recommendation 1: Increase Local Primary Health Care

In the family's view, the death of the Elder evidenced a need for an increase in health funding in the Kalkarindji and Daguragu communities. The family requested the Coroner recommend that the resources available for primary health care in the communities of Kalkarindji and Daguragu be increased.

The Coroner declined to make this recommendation on the basis that there was nothing before her to suggest that current funding levels were inadequate or that increased resources would have resulted in a different outcome in this matter.⁴¹

Recommendation 2: Trauma Counselling

Given the significant trauma the family and members of the Kalkarindji and Daguragu communities suffered as a result of the Elder's passing, the family requested that professional trauma counselling and mental health service delivery be made available to them as soon as possible, to assist them to cope.⁴²

The Coroner did not make this recommendation and gave no reasons why not.

Recommendation 3: Implementation of Senate Recommendations

In September 2007, the Commonwealth Senate Standing Committee on Community Affairs released a report entitled *Highway to Health: Better Access for Rural, Regional and Remote Patients*,⁴³ which made 16 recommendations for improving access to health in rural, regional and remote communities. The family requested that the Coroner recommend the adoption and implementation of these recommendations as a matter of urgency, with the highest priority given to recommendation 16. Recommendation 16 is specifically concerned with the improvement of Indigenous patients' access to health services and recommends the identification and adoption of best practice standards in the area.⁴⁴

The Coroner declined to recommend the adoption of the Senate recommendations, though she did express support for recommendation 1, which deals with the need for the next Australian Health Care Agreement to recognise the fundamental importance of patient assisted travel schemes.⁴⁵

Recommendation 4: Local Decision-Making

It was requested by the family that the Coroner recommend that the decision-making authority for escorts be housed in a local or regional setting with people who have direct access to the patient, potentially with broader use of the Katherine West Health Board and the staff of the Kalkarindji clinic.

The Coroner declined to make this recommendation, stating that the primary consideration in making a decision as to qualification for an escort will now be met by the Patient Risk Profiling Tool, which provides criteria against which a patient's need for an escort is to be assessed.⁴⁶

Recommendation 5: Advising Family

It was submitted by the family of the Elder that the family of a patient who is sent from the community to receive health care should be directly informed of their relative's travel arrangements at each step in the journey, and also when their family member is expected to return to the community.

The Coroner agreed with this submission and recommended that the implementation of an advice scheme be considered.⁴⁷

Recommendation 6: Treating Doctors

The family submitted that the Northern Territory Department of Health should institute a system whereby doctors treating patients from remote communities are required to specifically consider the patient's need for an escort for their journey home to their community. Should a treating doctor refuse an escort, they should record their reasons for doing so.

While the Coroner did not make this exact recommendation, she did recommend that, where a decision is made remotely by a District Medical Officer to refuse an escort, the reasons for the refusal should be recorded and a copy should be provided to the clinic requesting the escort. The Coroner also recommended that the need for an escort for persons from remote communities be emphasised in staff training as a primary consideration when determining patients' overall health needs and care.⁴⁸

Recommendation 7: Local Transport

The family requested a recommendation from the Coroner that local community members be hired by Katherine West Health Board to assist the staff at Kalkarindji clinic transport patients to and from the Kalkarindji airstrip when necessary.

The Coroner did not make this recommendation and gave no reasons why not.

Recommendation 8: Council Notification

The family submitted that PATS offices should be required to notify the Daguragu Council of all PATS flights inbound to the Kalkarindji airstrip at least 24 hours prior to the arrival of the aircraft, and that a recommendation to this effect be made. This was to safeguard against the potential for failures in communication between the Katherine Hospital and the Kalkarindji clinic to occur in the future.

The Coroner declined to make this recommendation, stating that the suggestion was not practical and that, in any event, it was not clear how it would provide any assistance.⁴⁹

Recommendation 9: Use of Interpreters at Katherine Hospital

The family requested the making of a recommendation that the Katherine West Health Board be required to seek assistance from an interpreter sourced from the Aboriginal Interpreter Service for a patient whose first language is an Aboriginal language. Where an interpreter is available, they should provide assistance to the patient at the time of admission and during treatment.

The Coroner agreed that, subject to interpreter availability, there should be greater use of interpreters at admission and during treatment for persons identified as requiring that assistance.⁵⁰

Recommendation 10: Use of Interpreters During the Investigation

The family considered that, when the Northern Territory Police are conducting interviews with potential witnesses who do not speak English as a first language in order to prepare witness statements for inclusion in an inquest brief, an interpreter from the Aboriginal Interpreter Service should be present. It was submitted by the family that a recommendation be made to this effect by the Coroner.

The Coroner did not make this recommendation and gave no reasons why not.

Comments

It is disappointing that the Coroner did not see fit to make more of the recommendations requested by the family. Given the

obvious distress shown by some members of the family and community during the inquest, it is particularly surprising that the Coroner did not address the family's request for the provision of trauma counselling in her decision.

VI Conclusion

It is evident from the inquest into the tragic death of the Elder that the exercise by coroners of their broad discretionary power as to the conduct of inquests can negatively impact on the experience of an inquest for the families of the deceased. Especially distressing to the Elder's family in this case was the Coroner's exercise of discretion in relation to the location of the inquest and the interpreter that was used. In order that similar distress to families might be avoided in future coronial inquests, there is a need for the implementation of guidelines giving guidance to coroners as to how they should exercise their discretion. As the inquest into the Elder's death indicated, this need for guidelines is particularly acute in relation to the location of an inquest and the use of interpreters during inquests.

Ultimately, what I hope the reader takes away from this article is that it is important for coroners, in making decisions about how an inquest is to be conducted, to give greater consideration to the feelings of the family. Coroners must recognise that, in the end, it is important to ensure that the family of the deceased comes away from an inquest feeling that they have had the best possible opportunity to put forward their point of view and that, in their eyes, justice has been done.

* Shannon Chapman is a lawyer with Blake Dawson, Perth. Many thanks to Emily Keys for her assistance. Blake Dawson seconds solicitors (two a year) to the North Australian Aboriginal Justice Agency ('NAAJA') to fill the position of Civil Lawyer at NAAJA's Katherine office. From June 2007 to July 2008 I filled that position. At that time, NAAJA's funding guidelines prevented NAAJA from representing a family at a coronial inquest where the death did not occur in custody. I was not subject to that restriction, which has since been lifted. After a barrister who consented to act in the matter on a pro bono basis withdrew from the case, Northern Territory Legal Aid consented to fund a barrister to represent the family at the inquest. The views expressed in this article are

those of the author, and do not necessarily represent those of Blake Dawson or NAAJA, and Blake Dawson and NAAJA take no responsibility for the views expressed in this article.

- 1 The Elder's family was represented by barrister Patrick McIntyre. I was the briefing solicitor.
- 2 Nothing in this article is intended to, or should be taken to, suggest that the Coroner was not entitled to exercise her discretion in the manner she did, that the Coroner exercised her discretion improperly, unreasonably or without taking the family's wishes into account, or that there was any sort of wrongdoing on the part of the Coroner or Counsel Assisting the Coroner.
- 3 This is an extract from a statement that was written by the Elder's nieces and read to the Coroner at the inquest.
- 4 This statement was contained in a statutory declaration made by Michael Paddy, one of the elders of Daguragu community and President of the Daguragu Community Government Council, which was submitted to the inquest.
- 5 The Northern Territory Department of Health and Community Services is responsible for the administration of Katherine Hospital.
- 6 The Northern Territory Department of Health and Community Services is responsible for the administration of the PATS scheme.
- 7 Letter from the author to Counsel Assisting the Coroner, 31 October 2007; email from the author to Counsel Assisting the Coroner, 5 November 2007; email from the author to Counsel Assisting the Coroner, 9 November 2007; letter from the author to Counsel Assisting the Coroner, 7 February 2008; letter from the author to Counsel Assisting the Coroner, 14 March 2008.
- 8 The family did not consider that it was proper for this report to be included in the brief to the Coroner because it: 'pursues certain lines of enquiry and makes conclusions that are rightly for the Coroner herself to investigate and determine, therefore purporting to perform the Coroner's role. We are also concerned about the actual and perceived independence of the report ...' Letter from the author to Counsel Assisting the Coroner, dated 26 October 2007. Note that Counsel Assisting the Coroner did state to the Coroner that the conclusions made in the report should be treated with some caution: Transcript of Proceedings, *Inquest into the Death of [the Elder]* (Northern Territory Coroner's Court, Ms Sue Oliver SM, 13 November 2007) 218.
- 9 Email from the author to Counsel Assisting the Coroner, 5 November 2007; email from the author to Counsel Assisting the Coroner, 6 November 2007; email from the author to Counsel Assisting the Coroner, 7 November 2007.
- 10 Email from Counsel Assisting the Coroner to the author, 7 November 2007.
- 11 Letter from the author to Counsel Assisting the Coroner, 31

- 12 October 2007; email from the author to Counsel Assisting the Coroner, 6 November 2007; email from the author to Counsel Assisting the Coroner, 9 November 2007.
- 13 Where in this article I refer to the Coroner advising of a particular matter, that advice was communicated to me by either one of the staff at the Coroner's office, or by Counsel Assisting the Coroner.
- 14 Where in this article I refer to the family being advised of a particular matter, that advice was communicated through me, as their legal representative, by either one of the staff at the Coroner's office or by Counsel Assisting the Coroner.
- 15 Email from James Ogilvy (previous Blake Dawson seconded to NAAJA) to the Deputy Coroner, 2 June 2007.
- 16 Letter from the Coroner's office to the author, 29 June 2007.
- 17 Letter from the author to Counsel Assisting the Coroner, 26 October 2007.
- 18 Letter from the author to Counsel Assisting the Coroner, 31 October 2007.
- 19 The Coroner did grant a request by the family that the inquest reconvene on the second day at 2:00 pm, to allow sufficient time for the family to travel to Katherine.
- 20 The Coroner was notified of the identity of these community members and that they were prepared to give evidence at the inquest.
- 21 There are cases where the whole of an inquest into a person's death has been held in the place where that person passed away. For some examples, see Northern Territory Department of Justice, *Coroner's Office: Inquests for 2001–2008* <<http://www.nt.gov.au/justice/courtsupp/coroner/inquestlist.shtml>> at 21 November 2008.
- 22 Note that there were other witnesses who also required an interpreter to give their evidence.
- 23 Letter from the author to Counsel Assisting the Coroner, 31 October 2007.
- 24 Email from the author to the Coroner, 9 November 2007.
- 25 Transcript of Proceedings, *Inquest into the Death of [the Elder]* (Northern Territory Coroner's Court, Coroner Oliver, 13 November 2007) 5.
- 26 The family's interpreter indicated to me that the interpreter was speaking in Kriol, not Gurindji.
- 27 Although the interpreter did speak some Gurindji, the interpreter mixed Gurindji and Kriol words together, rather than speaking straight Gurindji and was in the main translating the questions into Kriol.
- 28 A community member consented to travel to Katherine with the family and interpret for them during the proceedings.
- 29 See, eg, Queensland Criminal Justice Commission, *Aboriginal Witnesses in Queensland's Criminal Courts* (1996) ch 5, extracted in (1996) 1(4) *Australian Indigenous Law Reporter* 76.

- 29 Transcript of Proceedings, *Inquest into the Death of* [the Elder] (Northern Territory Coroner's Court, Coroner Oliver, 13 November 2007) 85, 150–2; Notes made by the author of the testimony of P Campos in the *Inquest into the Death of* [the Elder] (Coroner's Court, Ms Sue Oliver SM, 13 November 2007).
- 30 Transcript of Proceedings, *Inquest into the Death of* [the Elder] (Northern Territory Coroner's Court, Coroner Oliver, 13 November 2007) 156 (testimony of B McNamara and Dr Buchanan).
- 31 Transcript of Proceedings, *Inquest into the Death of* [the Elder] (Northern Territory Coroner's Court, Coroner Oliver, 13 November 2007) pages 150–2, 161.
- 32 *Inquest into the Death of* [the Elder] [2008] NTMC 057 (Unreported, Northern Territory Coroner's Court, Coroner Oliver, 1 September 2008) [56]–[58] <<http://www.nt.gov.au/justice/courtsupp/coroner/>> at 21 November 2008.
- 33 Ibid [56].
- 34 Notes made by the author of the testimony of A Cartress in the *Inquest into the Death of* [the Elder] (Coroner's Court, Ms Sue Oliver SM, 21 November 2007).
- 35 *Inquest into the Death of* [the Elder] [2008] NTMC 057 (Unreported, Northern Territory Coroner's Court, Coroner Oliver, 1 September 2008) [71] <<http://www.nt.gov.au/justice/courtsupp/coroner/>> at 21 November 2008.
- 36 Internal Memorandum from Senior Constable Meng to Officer in Charge, Katherine Investigation Unit, 20 March 2007.
- 37 Transcript of Proceedings, *Inquest into the Death of* [the Elder] (Northern Territory Coroner's Court, Coroner Oliver, 21 November 2007) 23–4.
- 38 *Inquest into the Death of* [the Elder] [2008] NTMC 057 (Unreported, Northern Territory Coroner's Court, Coroner Oliver, 1 September 2008) [20] <<http://www.nt.gov.au/justice/courtsupp/coroner/>> at 21 November 2008.
- 39 Ibid [33], [35]–[37].
- 40 Ibid [88].
- 41 Ibid [82].
- 42 Transcript of Proceedings, *Inquest into the Death of* [the Elder] (Northern Territory Coroner's Court, Coroner Oliver, 13 November 2007) 16, 52, 56; Counsel Assisting the Family, *Statement to the Inquest into the Death of* [the Elder], as annexed to the closing submissions.
- 43 Senate Standing Committee on Community Affairs, Parliament of Australia, *Highway to Health: Better Access for Rural, Regional and Remote Patients* (2007) <http://www.aph.gov.au/Senate/committee/clac_ctte/completed_inquiries/2004-07/pats/report/index.htm> at 14 November 2008.
- 44 Ibid xii.
- 45 *Inquest into the Death of* [the Elder] [2008] NTMC 057 (Unreported, Northern Territory Coroner's Court, Coroner Oliver, 1 September 2008) [80] <<http://www.nt.gov.au/justice/courtsupp/coroner/>> at 21 November 2008. See also Senate Standing Committee on Community Affairs, Parliament of Australia, above n 43, ix.
- 46 *Inquest into the Death of* [the Elder] [2008] NTMC 057 (Unreported, Northern Territory Coroner's Court, Coroner Oliver, 1 September 2008) [86] <<http://www.nt.gov.au/justice/courtsupp/coroner/>> at 21 November 2008.
- 47 Ibid [84].
- 48 Ibid [86].
- 49 Ibid [83].
- 50 Ibid [81].